| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PRUD-127155479* | *State:* | *Arkansas* |
| *Filing Company:* | *The Prudential Insurance Company of America* | *State Tracking Number:* | *48719* |
| *Company Tracking Number:* | *IIGH-GRP115001-LH-AR* | | |
| *TOI:* | *LTC03G Group Long Term Care* | *Sub-TOI:* | *LTC03G.001 Qualified* |
| *Product Name:* | *GRP 115001* | | |
| *Project Name/Number:* | *EVI Application Form/2715* | | |

## Filing at a Glance

Company: The Prudential Insurance Company of America

| | | |
|---|---|---|
| Product Name: GRP 115001 | SERFF Tr Num: PRUD-127155479 | State: Arkansas |
| TOI: LTC03G Group Long Term Care | SERFF Status: Closed-Approved | State Tr Num: 48719 |
| Sub-TOI: LTC03G.001 Qualified | Co Tr Num: IIGH-GRP115001-LH-AR | State Status: Approved-Closed |
| Filing Type: Form | | Reviewer(s): Harris Shearer, Stephanie Fowler |
| | Author: Laura Hughes | Disposition Date: 05/31/2011 |
| | Date Submitted: 05/09/2011 | Disposition Status: Approved |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: EVI Application Form | Status of Filing in Domicile: Pending |
| Project Number: 2715 | Date Approved in Domicile: |
| Requested Filing Mode: | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Group |
| Submission Type: New Submission | Group Market Size: Large |
| Group Market Type: Employer, Association | Overall Rate Impact: |
| Filing Status Changed: 05/31/2011 | |
| State Status Changed: 05/31/2011 | Deemer Date: |
| Created By: Laura Hughes | Submitted By: Laura Hughes |
| Corresponding Filing Tracking Number: | |

Filing Description:

Please see attached cover letter.

## Company and Contact

**Filing Contact Information**

| | |
|---|---|
| Karen Smyth, Vice President | karen.smyth@prudential.com |
| 2101 Welsh Road | 215-658-6279 [Phone] |
| Dresher, PA 19025 | 888-294-6332 [FAX] |

**Filing Company Information**

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PRUD-127155479* | *State:* | *Arkansas* |
| *Filing Company:* | *The Prudential Insurance Company of America* | *State Tracking Number:* | *48719* |
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| *TOI:* | *LTC03G Group Long Term Care* | *Sub-TOI:* | *LTC03G.001 Qualified* |
| *Product Name:* | *GRP 115001* | | |
| *Project Name/Number:* | *EVI Application Form/2715* | | |

| | | |
|---|---|---|
| The Prudential Insurance Company of America | CoCode: 68241 | State of Domicile: New Jersey |
| 751 Broad Street | Group Code: 304 | Company Type: Life |
| Newark, NJ 07102-3777 | Group Name: | State ID Number: |
| (973) 802-6000 ext. [Phone] | FEIN Number: 22-1211670 | |

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## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $50.00 |
| Retaliatory? | No |
| Fee Explanation: | |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| The Prudential Insurance Company of America | $50.00 | 05/09/2011 | 47396464 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PRUD-127155479* | *State:* | *Arkansas* |
| *Filing Company:* | *The Prudential Insurance Company of America* | *State Tracking Number:* | *48719* |
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| *Product Name:* | *GRP 115001* | | |
| *Project Name/Number:* | *EVI Application Form/2715* | | |

# Correspondence Summary

## Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved | Stephanie Fowler | 05/31/2011 | 05/31/2011 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PRUD-127155479* | *State:* | *Arkansas* |
| *Filing Company:* | *The Prudential Insurance Company of America* | *State Tracking Number:* | *48719* |
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| *TOI:* | *LTC03G Group Long Term Care* | *Sub-TOI:* | *LTC03G.001 Qualified* |
| *Product Name:* | *GRP 115001* | | |
| *Project Name/Number:* | *EVI Application Form/2715* | | |

# Disposition

Disposition Date: 05/31/2011
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PRUD-127155479* | *State:* | *Arkansas* |
| *Filing Company:* | *The Prudential Insurance Company of America* | *State Tracking Number:* | *48719* |
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| *TOI:* | *LTC03G Group Long Term Care* | *Sub-TOI:* | *LTC03G.001 Qualified* |
| *Product Name:* | *GRP 115001* | | |
| *Project Name/Number:* | *EVI Application Form/2715* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Accepted for Informational Purposes | Yes |
| **Supporting Document** | Application | | No |
| **Supporting Document** | Health - Actuarial Justification | | No |
| **Supporting Document** | Outline of Coverage | | No |
| **Supporting Document** | Cover Letter | Approved | Yes |
| **Form** | Insurability Profile and Medical History Application Form | Approved | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PRUD-127155479* | *State:* | *Arkansas* |
| *Filing Company:* | *The Prudential Insurance Company of America* | *State Tracking Number:* | *48719* |
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| *TOI:* | *LTC03G Group Long Term Care* | *Sub-TOI:* | *LTC03G.001 Qualified* |
| *Product Name:* | *GRP 115001* | | |
| *Project Name/Number:* | *EVI Application Form/2715* | | |

# Form Schedule

**Lead Form Number: GRP 115001**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved 05/31/2011 | GRP 115001 | Application/ Enrollment Form | Insurability Profile and Medical History Application Form | Revised | Replaced Form #: GRP 115001 Previous Filing #: GRP 113701 | 40.900 | GRP115001 Standard Medical History (Long).pdf |

The Prudential Insurance Company of America
Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176 • 1-800-732-0416



# Medical History & Insurability Form for Long Term Care Insurance

**INSTRUCTIONS:** Read and complete all necessary parts of this Medical History & Insurability Form. **Please print using blue or black ink.** Use an "X" to mark boxes where indicated. **Provide your signature in all areas required.** If you answer "NO" to each question, attach the completed Insurability Profile Form to your Enrollment Form and mail it in the enclosed, postage-paid envelope to: Prudential Long Term Care Unit, P.O. Box 8526, Philadelphia, PA 19176. *If you have questions, call 1-800-732-0416.*

**The following does not apply to residents of Florida, New Jersey, Oregon or Virginia.**

**Caution: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which is a crime that may result in criminal and/or civil penalties.**

**To residents of Florida**

**Caution: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.**

**To residents of New Jersey.**

**Caution: Any person who includes any false or misleading information on an application for coverage under a group policy is subject to criminal and civil penalties.**

**To residents of Virginia.**

**Caution: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits as application or files a claim containing a false or deceptive statement may have violated the state law.**

## A. APPLICANT INFORMATION

**Full name** **e-mail address:**

**Daytime phone** ( ) - **Evening phone** ( ) - Best time to call: ☐ AM ☐ PM

**Date on accompanying enrollment form** **Group Contract Holder** [(Employer/Association)]

## B. TELL US ABOUT YOUR INSURABILITY

**1. Within the past 7 years, have you had, currently have, or have you been diagnosed with or treated by or consulted a licensed health care practitioner for any of the following conditions:**

Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Kidney Failure, cirrhosis of the liver, Huntington's Disease, Post Polio Syndrome, Lou Gehrig's Disease (ALS), or other chronic neurological Disease/Disorder? ☐ Yes ☐ No

Alzheimer's disease, chronic memory loss, frequent or persistent forgetfulness, senility, dementia or organic brain syndrome, schizophrenia or mental retardation? ☐ Yes ☐ No

Type I diabetes (juvenile) ☐ Yes ☐ No

Type II diabetes (adult onset) with more than 50 units of insulin per day or in combination with any kidney condition, amputation, Transient Ischemic Attack (TIA) or any complications of nerves or eyes? ☐ Yes ☐ No

Metastatic cancer (cancer that has spread from the original site or location)?
Stroke (CVA), Transient Ischemic Attack (TIA) within the past 5 years or in combination with heart surgery, or more than one TIA? ☐ Yes ☐ No

**2. Within the past 12 months**, have you had, do you currently have, or have you been diagnosed with, or treated by or consulted a licensed health care practitioner for congestive heart failure, or for symptoms of congestive heart failure? ☐ Yes ☐ No

**3.Within the past 12 months** have you utilized any of the following:
Wheelchair, Motorized Scooter, Walker, Crutches, Quad Cane, Oxygen, Respirator, or Kidney Dialysis? ☐ Yes ☐ No

**4. Within the past 12 months,** have you been advised to utilize the services of or needed: home health care/home care, adult day care, or care in a nursing home, assisted living/ residential care facility, or other long term care facility? ☐ Yes ☐ No

**5.Do you currently need, receive, or been advised to receive assistance or supervision by another person for taking your medication or in performing any of the following: bathing, eating, toileting, bowel or bladder control (continence), dressing, walking, moving in or out of bed or chair?** ☐ Yes ☐ No

**6. This section pertains to Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) and, if permitted, HIV-related (Human Immunodeficiency Virus) diagnosis and treatment.**

**PLEASE COMPLETE THE SECTION BELOW THAT CORRESPONDS TO YOUR STATE OF RESIDENCE.**

***Minnesota Residents: Please read prior to answering the questions in the "ALL states" section below.***

You do NOT need to disclose any HIV (Human Immunodeficiency Virus or AIDS virus) tests that were given to you as:
1) a criminal offender or crime victim as a result of a crime that was reported to the police;
2) a patient who received the services of emergency medical services personnel at a hospital or medical care facility;
3) emergency medical personnel who were tested as a result of performing emergency medical services.

"Emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, and other persons who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital who experience a significant exposure to an inmate who is transported to facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan law.

**All states except Connecticut, Florida, Maine, Maryland, Vermont or Wisconsin**

Within the past 10 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner, as having any of the following medical conditions:

Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
AIDS Related Complex (ARC)? ☐ Yes ☐ No
Any HIV infection (Human Immunodeficiency Virus)? ☐ Yes ☐ No

**Connecticut, Maine and Wisconsin**

*You may answer these questions "No" if you have tested positive for HIV (Human Immunodeficiency Virus) and have not developed symptoms of the disease AIDS.*

Within the past 10 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner, as having any of the following medical conditions:

Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
AIDS Related Complex (ARC)? ☐ Yes ☐ No

**Florida**

Within the past 10 years, have you tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No

**Maryland**

Within the past 7 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner, as having any of the following medical conditions:

Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
AIDS Related Complex (ARC)? ☐ Yes ☐ No
Any HIV infection (Human Immunodeficiency Virus)? ☐ Yes ☐ No

**Vermont**

*You may answer these questions "No" if you have tested positive for HIV (Human Immunodeficiency Virus) and have not developed symptoms of the disease AIDS.*

Within the past 10 years, have you had, do you currently have, or have you been diagnosed by a licensed medical physician or treated by a Licensed Health Care Practitioner, as having any of the following medical conditions:

Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
AIDS Related Complex (ARC)? ☐ Yes ☐ No

**NOTE: If you answered "YES" to any question in Part B, do not complete the remainder of this form. We regret that we will be unable to offer you long-term care coverage because you do not meet our minimum acceptance criteria. If you answered "NO" to all questions in Part B, please continue.**

## C. TELL US ABOUT YOUR MEDICAL HISTORY

**1. Height:** ____ft ____in **Weight:** ____lbs **Gender:** ☐ Male ☐ Female

**2. List any activities in which you regularly participate outside your home (e.g., walking or gardening):**

**3. Have 2 or more years passed since you received any medical examination or treatment by a health care professional?** ☐ Yes ☐ No

**4. Who is your Primary Care Physician with most of your medical records?** (Please print neatly)

Name Phone

Address

City State Zip

Reason for last visit Date of last visit

**5. Within the past 3 years, have you been advised by a Licensed Health Care Practitioner to have surgery that has not been performed?** ☐ Yes ☐ No

Condition Date last treated

**6. Check the appropriate boxes for any care received within the past 3 years:**

Home health care ☐ Yes ☐ No
Adult day care ☐ Yes ☐ No
Nursing home, assisted living/residential care facility or other long-term care facility ☐ Yes ☐ No

**7. Within the past 5 years (7 years for cancer), have you received any advice or treatment from a Licensed Health Care Practitioner for, taken any medications for, or been medically diagnosed with:**

Any heart or circulatory conditions (angina, congestive heart failure, heart attack, heart surgery, irregular heart beat, high blood pressure, cerebrovascular disorder or peripheral vascular disease)? ☐ Yes ☐ No
Cancer of any kind, Hodgkin's disease, leukemia or lymphoma? ☐ Yes ☐ No

| | | |
|---|---|---|
| Tumors (non-cancerous) or skin ulcers, amputation or paralysis? | ☐ Yes | ☐ No |
| Any breathing conditions, such as asthma, chronic bronchitis, chronic obstructive pulmonary disease, emphysema, shortness of breath or tuberculosis? | ☐ Yes | ☐ No |
| Cirrhosis, diabetes or hepatitis? | ☐ Yes | ☐ No |
| Brain disorder, blackouts, convulsions, epilepsy or seizures? | ☐ Yes | ☐ No |
| Anxiety, depression or other mental, emotional or nervous disorder? | ☐ Yes | ☐ No |
| Alcoholism or chemical dependency? | ☐ Yes | ☐ No |
| Bone or spinal disorders such as osteoarthritis or rheumatoid arthritis, osteoporosis or joint replacement? | ☐ Yes | ☐ No |
| Numbness, dizziness or balance problems? | ☐ Yes | ☐ No |

**In the space below, provide details for any "YES" answers. If additional space is required, attach the details on a separate piece of paper, including your name and Social Security number. You must also sign and date that page.**

Condition/Medications Date Prescribed/Date last treated

Name, address and phone of the Licensed Health Care Practitioner who treated your condition:

Condition/Medications Date Prescribed/Date last treated

Name, address and phone of any other Licensed Health Care Practitioner who treated your condition:

**8. Within the past 5 years (7 years for cancer), have you received any advice or treatment from a Licensed Health Care Practitioner for any reason not previously stated?** ☐ Yes ☐ No
(For residents of Connecticut, Florida, Maine, Maryland, Vermont and Wisconsin,this does not include HIV testing (Human Immunodeficiency Virus).

*If you answered "YES", please provide details below.*

Condition/Medications Date Prescribed/Date last treated

☐ Check here if treated by your Primary Care Physician only.

Name, address and phone of any other Licensed Health Care Practitioner who treated your condition:

Condition/Medications Date Prescribed/Date last treated

☐ Check here if treated by your Primary Care Physician only.

Name, address and phone of any other Licensed Health Care Practitioner who treated your condition:

**9. Are you currently taking any drug or medication not listed above?** ☐ Yes ☐ No

*If you answered "YES", please provide details below.*

Drug or medication Dosage

How long have you been taking this medication? ☐ Check here if treated by your Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition:

Drug or medication Dosage

How long have you been taking this medication? ☐ Check here if treated by your Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition:

Drug or medication Dosage

How long have you been taking this medication? ☐ Check here if treated by your Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition:

Drug or medication Dosage

How long have you been taking this medication? ☐ Check here if treated by your Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition:

## D. READ AND SIGN APPLICANT AGREEMENTS

**Caution: If your answers on this form are incorrect or untrue, or fail to include all material medical information requested, Prudential may have the right to deny benefits or rescind your insurance coverage.**

To the best of my knowledge and belief, the answers on this Medical History and Insurability Form for Long Term Care Insurance are complete and true. I understand and agree:

- The information on this Medical History and Insurability Form for Long Term Care Insurance is the basis for the coverage for which I am applying to The Prudential Insurance Company of America (Prudential).
- My coverage will NOT take effect unless: Prudential has approved this Medical History and Insurability Form for Long Term Care Insurance and statements and answers given in applying for this coverage do not change materially until the date this Medical History and Insurability Form for Long Term Care Insurance is approved.
- I certify that I have read this Medical History and Insurability Form for Long Term Care Insurance or had it read to me, and I realize that any false statement or misrepresentation in this Medical History and Insurability Form for Long Term Care Insurance may result in loss of coverage under the Group Contract.

**X** Applicant Signature Date

The Prudential Insurance Company of America
Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176 • 1-800-732-0416

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PRUD-127155479* | *State:* | *Arkansas* |
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| *Product Name:* | *GRP 115001* | | |
| *Project Name/Number:* | *EVI Application Form/2715* | | |

# Supporting Document Schedules

**Item Status:** **Status Date:**

**Satisfied - Item:** Flesch Certification — Accepted for Informational Purposes — 05/31/2011

**Comments:**
Not applicable
**Attachment:**
AR - Readability Certification -5-2011.pdf

**Item Status:** **Status Date:**

**Bypassed - Item:** Application
**Bypass Reason:** Not applicable
**Comments:**

**Item Status:** **Status Date:**

**Bypassed - Item:** Health - Actuarial Justification
**Bypass Reason:** Not appicable
**Comments:**

**Item Status:** **Status Date:**

**Bypassed - Item:** Outline of Coverage
**Bypass Reason:** Not appicable
**Comments:**

**Item Status:** **Status Date:**

**Satisfied - Item:** Cover Letter — Approved — 05/31/2011
**Comments:**
**Attachment:**

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PRUD-127155479* | *State:* | *Arkansas* |
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AR Filing Letter - 5-2011.pdf

**C E R T I F I C A T I O N**
**OF**
**R E A D A B I L I T Y**

**THE PRUDENTIAL INSURANCE COMPANY OF AMERICA** hereby certifies that this filing complies with Arkansas Code ACA 23-80-206, Policy Language Simplification Standards and achieves a Flesch reading ease test score as shown below.

Karen L. Smyth

Signature

**Karen L. Smyth**
Name

**Vice President**
Title

**May 5, 2011**
Date

Line of
Insurance: **Health Insurance**
Subline: **Long Term Care**

Policy Form Number/s:

| FORM NUMBER | SCORE |
|---|---|
| GRP 115001 | 40.1 |

**Karen L. Smyth, FLMI, ACS, AIAA, AIRC, CLTC, LTCP**
Vice President
Group Insurance

The Prudential Insurance Company of America
Long Term Care Unit
2101 Welsh Road
Dresher, Pennsylvania 19025
Tel 215 658-6279 Fax 888 294-6332

May 5, 2011

The Honorable Jay Bradford
Commissioner of Insurance
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: NAIC Number 304-68241
Group Long Term Care Insurance
Form Number: GRP 115001 (formerly GRP 113701)

Dear Commissioner Bradford:

In support of Prudential's Group Long Term Care Insurance, we enclose for your review and approval, the revised insurance form listed above. This form was previously reviewed and approved by the Department on February 9, 2009 – SERFF Tracking Number: SERT-6LRF6491 and Department File Number: 31882.

This form represents Prudential's group long term care insurance product line. It is a medical underwriting form (long form) intended for use with employer and association groups when we offer our currently marketed group long-term care insurance coverage.

The questions under Section B "Tell Us About Your Insurability," have been revised to mirror the Section B of the Simplified Issue form (GRP 114914) which was reviewed and approved by the Department on December 20, 2010 (PRUD-126924976). In addition, there has been a slight modification to Question 8 in Section C.

In view of the above explanation, we are requesting your re-approval of this form with the amendments as explained above. I also certify that with the exception of the changes mentioned above, there have been no other changes made to this form.

In view of the above explanation, we are requesting your re-approval of this form with the amendments as explained above. I also certify that with the exception of the changes mentioned above, there have been no other changes made to this form.

If there are any additional questions regarding this filing or you require further information, please do not hesitate to contact my associate:

Laura Hughes, CLTC, LTCP
Lead Analyst
The Prudential Insurance Company of America
2101 Welsh Road, LTC Unit
Dresher, PA 19025
(215) 658-6282
Fax: (888) 294-6332
e-mail: laura.hughes@prudential.com

Very truly yours,

Karen L. Smyth
Vice President

Enclosure